ATTACHMENT 1
BOILERPLATE MHP CONTRACT CHANGES 2003-04

EXHIBIT A, ATTACHMENT 1

E. Quality Management

The Contractor shall implement a Quality Management Program in accordance with Title 9, CCR, Section 1810.440 and Appendix A (consisting of three pages) and Appendix B (consisting of two pages), which are incorporated herein by reference, for evaluating the appropriateness and quality of the covered services provided to beneficiaries. References to the mental health plan (MHP) in Appendices A and B are references to the Contractor. The Contractor shall provide the Department with reports generated through the Quality Management Program on request.

The Contractor shall ensure that all covered services delivered by organizational providers are provided under the direction of a physician; a licensed/waivered psychologist; a licensed/registered/waivered social worker; a licensed/registered/waivered marriage, family and child counselor; or a registered nurse.

~~The Contractor shall include a study of Latino access in the annual Quality Improvement Workplan required by Appendix A, Section B that is effective on or after July 1, 2002. The required study may examine initial or secondary access issues. Initial access studies may include, but are not limited to studies of: outreach efforts to increase access, stigma, and healthcare/mental health partnerships related to access. Secondary access studies may include, but are not limited to studies of retention, the effect of extended hours, or barriers for Latinos with limited english proficiency. The required study shall, at the Contractor's election, meet the Contractor's obligation to conduct any single item required by Appendix A, Section B, Items 1, 2, 3, or 5. The required study may also meet the Contractor's obligation to conduct one of the clinical studies required by Appendix A, Section B, Item 4, if the Contractor will be studying a clinical issue related to access. The Contractor may chose to develop an access study that includes Latino and other underserved populations, rather than a study that focuses exclusively on Latino populations. The Contractor shall provide the Department with information on the design, progress and outcome of the study upon request.~~

The Contractor shall provide the Department with information on the design, progress and outcome of the study of Latino access if required by Exhibit A, Attachment 1, Section E, of the Contractor's Fiscal Year 2002-03 contract with the Department, upon request. If the Contractor was required to complete this study and has not completed the study, the Contractor may elect to continue the study beyond June 30, 2004. If the Contractor makes this election, the Contractor shall initiate the study prior to January 1, 2004 and shall notify the Department of the Contractor's intent to conduct an extended study. If the Contractor does not make this election, the Contractor shall complete the study by June 30, 2004.

K. Certification of Organizational Providers

The Contractor shall certify the organizational providers that subcontract with the Contractor to provide covered services in accordance with Title 9, CCR, Section 1810.435 and the requirements specified in Appendix D (consisting of two pages), which is herein incorporated by reference, prior to the date on which the provider begins to deliver services under the contract, and once every two years after that date, except as provided in ~~this section and in~~ Appendix D. The on site review required by Title 9, CCR, Section 1810.435(d) as a part of the certification process, will be made of any site owned, leased, or operated by the provider and used to deliver covered services to beneficiaries, except that on-site review is not required for public school or satellite sites.

~~If the Department has performed a similar certification of the provider for participation in the Short-Doyle/Medi-Cal program, certification by the Contractor is not required prior to delivery of services under this contract and the next certification will be due within two years of the date of the last certification by the Department, except as provided in Appendix D.~~

The Contractor may allow an organizational provider to begin delivering covered services to beneficiaries at a site subject to on site review prior to the date of the on site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on site review is the latest of the date the provider requested certification in accordance with the Contractor's certification procedures, the date the site was operational or the date a required fire clearance was obtained. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the provider begins delivering covered services to beneficiaries at the site.

The Contractor may allow an organizational provider to continue delivering covered services to beneficiaries at a site subject to on site review as part of the biennial recertification process prior to the date of the on site review, provided the site is operational and has any required fire clearances. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the biennial recertification of the provider is due.

Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the sites operated by an organizational provider to facilitate the claiming of federal financial participation by the Contractor and the Department's tracking of that information.

Y. Requirements for Day Treatment Intensive and Day Rehabilitation

1. Authorization and Service Requirements

The Contractor shall implement the following policies and procedures pertaining to day treatment intensive and day rehabilitation, as defined in Title 9, CCR, Sections 1810.213 and 1810.212 respectively, no later than September 1, 2003:

The Contractor shall require providers to request an initial mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, from the Contractor for day treatment intensive and for day rehabilitation. Provider as used in this section includes Contractor staff. The Contractor shall require providers to request MHP payment authorization from the Contractor in advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week. The Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive at least every three months and day rehabilitation at least every six months. The Contractor's MHP payment authorization function must meet the criteria of Title 9, CCR, Section 1830.215, except that the Contractor shall not delegate the MHP payment authorization function to providers. In the event that the Contractor is the day treatment intensive or day rehabilitation provider, the Contractor shall assure that the MHP payment authorization function does not include Contractor staff involved in providing day treatment intensive or day rehabilitation.

The Contractor shall require providers to request initial MHP payment authorization from the Contractor for counseling, psychotherapy or other similar therapeutic interventions that meet the definition of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic behavioral services as described in DMH Letter No. 99-03, that will be provided on the same day that day treatment intensive or day rehabilitation is being provided to the beneficiary. The Contractor shall require the providers of these services to request MHP payment authorization from the Contractor for continuation of these services on the same cycle required for continuation of the concurrent day treatment intensive or day rehabilitation for the beneficiary. The Contractor shall not delegate the MHP payment authorization function to the provider of day treatment intensive or day rehabilitation or the provider of the additional services.

In addition to meeting the requirements of Title 9, CCR, Sections 1840.318, 1840.328, 1840.330, 1840.350, and 1840.352, the Contractor shall require that providers of day treatment intensive and day include the following minimum service components in day treatment intensive or day rehabilitation:

a. Community meetings, which mean meetings that occur at a minimum once a day, but may occur more frequently as necessary, to address issues pertinent to the continuity and effectiveness of the therapeutic milieu that may, but are not required to be part of the continuous therapeutic milieu; actively involve staff and clients; for day treatment intensive, include a staff person whose scope of practice includes psychotherapy; for day rehabilitation, include a staff person who is a physician; a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; a registered nurse, a psychiatric technician, a licensed vocational nurse, or a mental health rehabilitation specialist; address relevant items including, but not limited to what the

schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up.

b. A therapeutic milieu, which means a therapeutic program that is structured by the service components described in subsections a. and b. below with specific activities being performed by identified staff; takes place for the continuous scheduled hours of operation for the program (more than four hours for a full-day program and a minimum of three hours for a half-day program); includes staff and activities that teach, model and reinforce constructive interactions; includes peer and staff feedback to clients on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress; involves clients in the overall program, for example, by providing opportunities to lead community meetings and to provide feedback to peers; includes behavior management interventions that focus on teaching self-management skills that children, youth, adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention.

The therapeutic milieu service components described in subsections 1) and 2) below must be made available during the course of the therapeutic milieu for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. (For example, a full-day program that operates five days per week would need to provide a total of 15 hours for the week; a full-day program that operates for seven days a week would need to provide a total of 21 hours for the week.)

1) Day rehabilitation must include:

a) Process groups, which are groups facilitated by staff to help clients develop the skills necessary to deal with their individual problems and issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.

b) Skill building groups, which are groups in which staff help clients to identify barriers related to their psychiatric and psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.

c) Adjunctive therapies, which are non-traditional therapies in which both staff and clients participate that utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of

self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

2). Day treatment intensive must include:

a) Skill building groups and adjunctive therapies as described in subsection 1)b) and c) above. Day treatment intensive may also include process groups as described in subsection 1)a) above.

b) Psychotherapy, which means the use of psychosocial methods within a professional relationship to assist the client or clients to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy must be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

c. An established protocol for responding to clients experiencing a mental health crisis. The protocol must assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the client's urgent or emergency psychiatric condition (crisis services). If clients will be referred to crisis services outside the day treatment intensive or day rehabilitation program, the day treatment intensive or day rehabilitation staff must have the capacity to handle the crisis until the client is linked to the outside crisis services.

d. A detailed weekly schedule that is available to clients and, as appropriate, to their families, caregivers or significant support persons a detailed written weekly schedule that identifies when and where the service components of program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their responsibilities.

e. Staffing ratios that are consistent with the requirements in Title 9, CCR, Sections 1840.350 and 1840.352, and, for day treatment intensive, that include at least one staff person whose scope of practice includes psychotherapy.

Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic milieu, e.g., time for travel, documentation, and caregiver contacts.

The Contractor shall require that at least one staff person is present and available to the group in the therapeutic milieu for all scheduled hours of operation.

The Contractor shall require that if day treatment intensive or day rehabilitation staff are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program), a clear audit trail is documented by the provider. The Contractor shall require that there be documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

f. An expectation that the beneficiary will be present for all scheduled hours of operation for each day. When a beneficiary is unavoidably absent for some part of the hours of operation, the Contractor shall ensure that the provider receives Medi-Cal reimbursement for day treatment intensive and day rehabilitation for an individual beneficiary only if the beneficiary is present for at least 50 percent of the scheduled hours of operation for that day.

g. Documentation of day treatment intensive and day rehabilitation that meets the documentation standards described in Exhibit A-Attachment 1-Appendix C. For day treatment intensive these standards include daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.

h. At least one contact (face-to-face or by an alternative method (e.g., e-mail, telephone, etc.)) per month with a family member, caregiver or other significant support person identified by an adult client, or one contact per month with the legally responsible adult for a client who is a minor. Adult clients may choose whether or not this service component is done for them. The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration. It is expected that this contact will occur outside hours of operation and the therapeutic milieu for day treatment intensive and day rehabilitation.

i. A written program description for day treatment intensive and day rehabilitation. Each provider of these services, including Contractor staff, shall be required to develop and maintain this program description. The written program description must describe the specific activities of the service and reflect each of the required components of the services described in this section. The Contractor shall review the written program description for compliance with this section for individual and group providers that begin delivering day treatment intensive or day rehabilitation on or after September 1, 2003 prior to the date the provider begins delivering day treatment intensive or day rehabilitation. The Contractor shall review the written program description for compliance

with this section for individual and group providers that were providing day treatment intensive or day rehabilitation prior to September 1, 2003 no later than June 30, 2004.

2. The Contractor shall retain the authority to set additional higher or more specific standards than those set by in this contract, provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary day treatment intensive and day rehabilitation.

3. Implementation of Authorization Requirements

The Contractor shall implement these MHP payment authorization requirements effective September 1, 2003, for beneficiaries whose initial referral for day treatment intensive or day rehabilitation occurs on or after September 1, 2003. For beneficiaries who were receiving day treatment intensive or day rehabilitation prior to September 1, 2003, the Contractor shall require providers to request MHP payment authorization from the Contractor for continuation of day treatment intensive no later than November 30, 2003 and day rehabilitation no later than March 31, 2004. The Contractor shall require providers to follow the same timelines for MHP payment authorization of mental health services as defined in Title 9, CCR, Section 1810.227, excluding services to treat emergency and urgent conditions as defined in Title 9, CCR, Sections 1810.216 and 1810.253 and excluding therapeutic behavioral services as described in DMH Letter No. 99-03, provided on the same day as day treatment intensive or day rehabilitation.

Z. MHP Payment Authorization Requirements for Therapeutic Behavioral Service

Therapeutic behavioral service (TBS) is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health service as defined in Title 9, CCR, Section 1810.215. TBS is an intensive one-to-one, short-term outpatient treatment intervention for beneficiaries under age 21 with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis and need additional short-term specific support services. TBS must be needed to prevent placement in a group home at Rate Classification Level (RCL) 12 through 14 or a locked facility for the treatment of mental health needs or to enable a transition from any of those levels to a lower level of residential care.

Effective September 1, 2003, the Contractor shall require providers to request initial and on-going mental health plan (MHP) payment authorization, as defined in Title 9, CCR, Section 1810.229, for TBS as described below. The Contractor shall not delegate the authorization function to providers. Provider as used in this section includes Contractor staff. In the event that the Contractor is the TBS provider, the Contractor shall assure that the authorization process does not include staff involved in providing TBS. The Contractor shall require providers to submit MHP payment authorization requests prior to the end of the specified hours or days in the current authorization period and shall make timely decisions on MHP payment authorization requests to ensure there is no break in medically necessary services to the beneficiary.

When the Contractor's MHP payment authorization decisions result in denial, modification, deferral, reduction or termination of the services requested by the provider, the Contractor shall provide notices of action (NOAs) in accordance with the requirements of Title 9, CCR, Section 1850.210, and, when required by Title 9, CCR, Section 1850.215, the continuation of services pending a fair hearing decision. When applicable, the NOA must advise the beneficiary of the right to request continuation of previously authorized services pending the outcome of a Medi-Cal fair hearing if the request for hearing is timely.

The MHP payment authorization requirements of this section replace the Contractor's obligations under DMH Letter No. 99-03, page 6, to review the TBS component of a beneficiary's client plan monthly.

1. General Authorization Requirements

   a. The Contractor shall require providers to request MHP payment authorization for TBS in advance of the delivery of the services included in the authorization request.

   b. The Contractor shall make decision on MHP payment authorization requests for TBS in advance of service delivery for the first authorization and subsequent reauthorizations of TBS.

   c. Both the initial authorization and subsequent reauthorization decisions must be made by a licensed practitioner of the healing arts (LPHA) as required by Title 9, CCR, Section 1830.215.

   d. The Contractor shall issue a decision on an MHP payment authorization request for TBS no later than 14 calendar days of receipt of the request.

   e. The Contractor retains the authority to set additional standards necessary to manage the delivery of TBS, including but not limited to establishing maximum hours for individual TBS service components (e.g., assessment, client plan development, and collateral services), provided the Contractor's standards are consistent with applicable state and federal laws and regulations and do not prevent the delivery of medically necessary TBS.

2. Initial Authorization

   The Contractor shall not approve an initial MHP payment authorization request that exceeds 30 days or 60 hours, whichever is less, except as specified in subsection 3.c. below. The initial authorization shall cover the provider conducting an initial TBS assessment, which must identify at least one symptom or behavior TBS will address; developing an initial TBS client plan, which must identify at least one TBS intervention; and providing the initial delivery of direct one-to-one TBS.

3. Reauthorization

a. The Contractor shall not approve an MHP payment authorization request for reauthorization of TBS that exceeds 60 days or 120 hours, whichever is less.

b. If the Contractor approved a provider's initial MHP payment authorization request under the provisions of subsection 2. above, the Contractor shall not approve the provider's first request for reauthorization unless the provider's request includes a TBS client plan that meets the following criteria:

1) A TBS client plan may be a separate client plan for the delivery of TBS or a component of a more comprehensive client plan. The TBS client plan is intended to provide clinical direction for one or a series of short-term intervention(s) to address very specific behaviors and/or symptoms of the beneficiary as identified by the assessment process.

2) Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS.

3) A specific plan of intervention for each of the targeted behaviors or symptoms identified in the assessment and the client plan.

4) A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.

5) A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in planned interventions when the original plans are not achieving expected results.

6) A transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks (which are the objectives that are met as the beneficiary progresses towards achieving client plan goals) have been reached or when reasonable progress towards goals is not occurring and, in the clinical judgment of the individual or treatment team developing the plan, are not reasonably expected to be achieved. This plan should address assisting parents/caregivers with skills and strategies to provide continuity of care when TBS is discontinued.

7) As necessary, a plan for transition to adult services when the beneficiary turns 21 years old and is no longer eligible for TBS. This plan should also address assisting parents/caregivers with skills and strategies to provide continuity of care when this service is discontinued, when appropriate in the individual case.

8) If the beneficiary is between 18 and 21 years of age, notes regarding any special considerations that should be taken into account, e.g., the identification of an adult case manager.

c. When the provider's initial request for MHP payment authorization includes a completed TBS assessment and TBS client plan that meets the requirements of subsection b.1) through 7), the Contractor may authorize TBS services consistent with the limits of this section, i.e., an initial MHP payment authorization request that covers direct one-to-one TBS that are fully supported by an assessment and TBS client plan may be approved for 60 days or 120 hours, whichever is less.

d. The Contractor shall base decisions on MHP payment authorization requests for reauthorization of TBS on clear documentation of the following and any additional information from the TBS provider required by the Contractor:

1) The beneficiary's progress towards the specific goals and timeframes of the TBS client plan. A strategy to decrease the intensity of services and/or to initiate the transition plan and/or terminate services when TBS has been effective for the beneficiary in making progress towards specified measurable outcomes identified in the TBS plan or the beneficiary has reached a plateau in benefit effectiveness.

2) If applicable, the beneficiary's lack of progress towards the specific goals and timeframes of the TBS client plan and changes needed to address the issue. If the TBS being provided to the beneficiary has not been effective and the beneficiary is not making progress as expected towards identified goals, the alternatives considered and the reason that only the approval of the requested additional hours/days for TBS instead of or in addition to the alternatives will be effective.

3) The review and updating of the TBS client plan as necessary to address any significant changes in the beneficiary's environment (e.g., a change in residence).

4) The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

f. When the Contractor approves a fourth MHP payment authorization request for a beneficiary, the Contractor shall provide a summary of the TBS services provided, justification for the additional authorization and a termination plan with clearly established timelines and benchmarks, including a planned date for termination of TBS, in writing to the Mental Health Director for the Contractor and to the Deputy Director, Systems of Care, Department of Mental Health, within five working days of the authorization decision.

4. Implementation of Authorization Requirements

The Contractor shall implement these MHP payment authorization requirements effective September 1, 2003, for beneficiaries whose initial referral for TBS occurs on or after September 1, 2003. For beneficiaries who were receiving direct one-to-one TBS or who had been referred to a provider that would provide both the initial assessment of the need for TBS and direct one-to-one TBS prior to September 1, 2003, the Contractor shall complete the reauthorization for on-going TBS by November 1, 2003.

AA. Program Integrity Requirements

Effective August 13, 2003 the Contractor shall initiate the process for compliance with Title 42, Code of Federal Regulations (CFR), Section 438.608. The Contractor shall provide the Department will a written statement of the Contractor's progress in implementing the requirement no later than October 15, 2003 and an update on progress on January 15, 2004 and April 15, 2004. Title 42, CFR, Section 438.608, in which the Contractor is a PIHP (Prepaid Inpatient Health Plan), provides:

Sec. 438.608 Program integrity requirements.
(a) General requirement. The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.
(b) Specific requirements. The arrangements or procedures must include the following:
(1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
(2) The designation of a compliance officer and a compliance committee that are accountable to senior management.
(3) Effective training and education for the compliance officer and the organization's employees.
(4) Effective lines of communication between the compliance officer and the organization's employees.
(5) Enforcement of standards through well-publicized disciplinary guidelines.
(6) Provision for internal monitoring and auditing.
(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO's or PIHP's contract.

EXHIBIT A, ATTACHMENT 1, APPENDIX C

DOCUMENTATION STANDARDS FOR CLIENT RECORDS

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2. Timeliness/Frequency of Progress Notes:

Progress notes will be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment Intensive effective September 1, 2003.

c. Weekly

- Day Treatment Intensive, effective July 1, 2003 through August 31, 2003
- Effective September 1, 2003, Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.
- Day Rehabilitation
- Adult Residential

EXHIBIT A, ATTACHMENT 1, APPENDIX D

PROVIDER CERTIFICATION BY THE CONTRACTOR OR THE DEPARTMENT

As a part of the organizational provider certification requirements in Exhibit A, Attachment 1, Section L, and Exhibit E, Section 5, Item E, the Contractor and the Department respectively will verify, through an on-site review if required by those sections or if determined necessary by the Contractor or the Department respectively, that:

. . . . .

11. For organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with Exhibit A, Attachment 1, Section

Y, paragraph 1. This requirement applies to new providers beginning August 1, 2003 and providers being recertified on or after March 1, 2004..

. . . . .

When an on site review of an organizational provider would not otherwise be required and the provider provides day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Exhibit A, Attachment 1, Section Y, paragraph 1. The Contractor must complete this review of new organizational providers for which on-site review is not required beginning September 1, 2003 and of any other organizational providers for which on-site review is not required by June 30, 2004.

. . . . .

EXHIBIT B, PAYMENT PROVISIONS

SECTION 4. AMOUNTS PAYABLE

The total amount payable for the 2003-2004 Fiscal Year ending June 30, 2004 is $_____. ~~Of the total amount payable for the 2002-2003 Fiscal Year, $_____ is additional state funds for covered services provided to beneficiaries residing in institutions for mental diseases~~. The amount payable is an interim amount only and is subject to the development of the allocation amount for the 2003-2004 Fiscal Year pursuant to Item 7. Any requirement of performance by the Department and the Contractor for this period will be dependent upon the availability of future appropriations by the Legislature for the purpose of this contract. The services shall be provided at the times required by this contract.

SECTION 6. PAYMENT IN FULL

The amount payable under Item 4, referred to hereafter as the allocation amount, constitutes payment in full by the Department of the State matching funds on behalf of beneficiaries for all covered services and for all utilization review and administrative costs incurred by the Contractor in providing or arranging for such services, except for the additional state matching funds ~~for covered services to beneficiaries residing in institutions for mental diseases and~~ for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits.

~~The total amount payable in Item 4 includes an amount equal to state matching share of the historical cost of psychiatrist and psychologist services provided in the fee-for-service Medi-Cal program, which is not separately identified. The total amount payable also includes a separately identified amount in Item 4, which equals the federal matching funds for these costs. This amount is included to reflect the fact that federal funds are not available for these services. The separately identified amount for covered services to beneficiaries residing in institutions for mental diseases will be reviewed by the Department to ensure that the amount reasonably reflects the historical cost of psychiatrist and psychologist services provided in the fee-for-service Medi-Cal program.~~

~~The amount payable under Item 4 for these services may be amended based on this review and the availability of state funds.~~

State matching funds, in addition to the amount payable under Item 4, for covered services, other than psychiatric inpatient hospital services, provided to beneficiaries under 21 years of age who are eligible for the full scope of Medi-Cal benefits will be paid in accordance with the Interagency Agreement between the Department and the State Department of Health Services (DHS 02-25271; DMH 02-72210-000 or subsequent agreement), which provides the federal financial participation and specified state matching funds for the Medi-Cal specialty mental health services and related activities

EXHIBIT E. ADDITIONAL PROVISIONS

SECTION 5 - HIPAA BUSINESS ASSOCIATE AGREEMENT

The Contractor, referred to in this section as Business Associate. shall comply with, and assist the Department in complying with, the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), including but not limited to Title 42, United States Code, Section 1320d et seq. and its implementing regulations (including but not limited to Title 45, CFR, Parts 142, 160, 162, and 164), hereinafter collectively referred to as the "Privacy Rule." Terms used but not otherwise defined in this section shall have the same meaning as those terms are used in the Privacy Rule.

If the Department becomes aware of a pattern of activity that violates this section and reasonable steps to cure the violation are unsuccessful, the Department will terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

A. Use and Disclosure of Protected Health Information

1. Except as otherwise provided in this section, Business Associate may use or disclose protected health information (PHI) to perform functions, activities or services for or on behalf of the Department, as specified in this contract, provided that such use or disclosure would not violate the Privacy Rule if done by the Department or the minimum necessary policies and procedures of the Department.

2. Except as otherwise limited in this section, Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

3. Except as otherwise limited in this section, Business Associate may use PHI to provide data aggregation services related to the health care operation of the Department.

B. Further Disclosure of PHI

Business Associate shall not use or further disclose PHI other than as permitted or required by this section or as required by law.

C. Safeguard of PHI

Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this section.

D. Unauthorized Use or Disclosure of PHI

Business Associate shall report to the Department any use or disclosure of the PHI not provided for by this section.

E. Mitigation of Disallowed Uses and Disclosures

Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by the Business Associate in violation of the requirements of this section.

F. Agents and Subcontractors of the Business Associate

Business Associate shall ensure that any agent, including a subcontractor, to which the Business Associate provides PHI received from, or created or received by the Business Associate on behalf of the Department, shall comply with the same restrictions and conditions that apply through this section to the Business Associate with respect to such information.

G. Access to PHI

Business Associate shall provide access, at the request of the Department, and in the time and manner designated by the Department, to the Department or, as directed by the Department, to PHI in a designated record set to an individual in order to meet the requirements of Title 45, CFR, Section 164.524.

H. Amendment(s) to PHI

Business Associate shall make any amendment(s) to PHI in a designated record set that the Department directs or at the request of the Department or an individual, and in the time and manner designated by the Department in accordance with Title 45, CFR, Section 164.526.

I. Documentation of Uses and Disclosures

Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for the Department to respond to a request by an individual for an accounting of disclosures of PHI in accordance with Title 45, CFR, Section 164.528.

J. Accounting of Disclosure

Business Associate shall provide to the Department or an individual, in time and manner designated by the Department, information collected in accordance with Title 45, CFR, Section 164.528, to permit the Department to respond to a request by the individual for an accounting of disclosures of PHI in accordance with Title 45, CFR, Section 164.528.

K. Records Available to the Department and Secretary of HHS

Business Associate shall make internal practices, books and records related to the use, disclosure, and privacy protection of PHI received from the Department, or created or received by the Business Associate on behalf of the Department, available to the Department or to the Secretary of HHS for purposes of the Secretary determining the Department's compliance with the Privacy Rule, in a time and manner designed by the Department or the Secretary of HHS.

L. Retention, Transfer and Destruction of Information on Contract Termination

1. Upon termination of the contract for any reason, Business Associate shall retain all PHI received from the Department, or created or received by the Business Associate on behalf of the Department in accordance with Exhibit A, Attachment 1, Section P of this contract in a manner that complies with the Privacy Rules. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate.

2. Prior to termination of the contract, the Business Associate may be required by the Department to provide copies of PHI to the Department in accordance with Exhibit A, Attachment 1, Section Q. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate.

3. When the retention requirements on termination of the contract have been met, the Business Associate shall destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department. This provision shall apply to PHI in possession of subcontractors or agents of the Business Associate. Business Associate, its agents or subcontractors shall retain no copies of the PHI.

4. In the event that Business Associate determines that destroying the PHI is not feasible, Business Associate shall provide the Department notification of the conditions that make destruction infeasible. Upon mutual agreement of the parties that the destruction of the PHI is not feasible, Business Associate shall extend the protections of this section to such PHI and limit further use and disclosures of such PHI for so long as Business Associate, or any of its agents or subcontractors, maintains such PHI.

M. Amendments to Section

The Parties agree to take such action as is necessary to amend this section as necessary for the Department to comply with the requirements of the Privacy Rule and its implementing regulations.

N. Material Breach

If the Department becomes aware of a pattern of activity that violates this section and reasonable steps to cure the violation are unsuccessful, the Department will terminate the contract, or if not feasible; report the problem to the Secretary of HHS.

O. Survival

The respective rights and obligations of Business Associate shall survive the termination of this contract.

P Interpretation

Any ambiguity in this section shall be resolved to permit the Department to comply with the Privacy Rule.